REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY PART – C (Revised)

(TO BE FILLED IN BLOCK LETTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL:

a. Name of TPA/Insurance company: PARK MEDICLAIM / ORIENTAL INS.

b. Toll free phone number: _____

c. Toll free fax: _____

d. Name of Hospital: ICLINIX ADVANCED EYECARE

i. Address: 27/111 UKRAM UNAO, UTTAR PRADESH

ii. Rohini ID: _____

iii. e-mail id: _____

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient: SANWAR MAL

B. Gender: ☑ Male ☐ Female ☐ Third Gender

C. Age: 62 (Years) / (Month)

D. Date of Birth: 31-12-1960 (DD/MM/YYYY)

E. Contact number: 9416852253

F. Contact number of attending Relative: _____

G. Insured Card ID number: _____

H. Policy number/Name of Corporate: 261298/48/2023/111

I. Employee ID: _____

J. Currently do you have any other mediclaim /health insurance: ☐ Yes ☑ No

i.Company Name: _____

ii.Give Details: N/A

K: Do you have a family Physician: ☐ Yes ☑ No

L: Name of the Family Physician: _____

M: Contact number, if any: _____

N: Current Address of Insured Patient: N/A

O: Occupation of Insured Patient: _____

(PLEASE COMPLETE DECLARATION OF THIS FORM)

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A: Name of the treating Doctor: DR VARUN GOYAL

B: Contact number: 9911324110

C: Nature of Illness/Disease with presenting complaint: BOY IN B/E

D: Relevant Critical Findings: B/E MULTIPLE LATTICE THOLE

E: Duration of the present ailment _____ Days

i. Date of First consultation: DD/MM/YYYY

ii. Past history of present ailment, if any _____

F: Provisional diagnosis: B/E MULTIPLE LATTICE THOLE

i. ICD 10 code _____

G: Proposed line of treatment:

i.	Medical Management	( )
ii.	Surgical Management	(✓)
iii.	Intensive care	( )
iv.	Investigation	( )
v.	Non-allopathic treatment	( )

H: If investigation and/or Medical Management, provide details _____

i. Route of Drug Administration _____

I: If surgical, name of surgery B/E LASER BARRAGE - 3 QUADRANT

i. ICD 10 PCS code _____

J: If other treatment, provide details N/A

K: How did injury occur _____

L: In case of accident

i.	Is it RTA:	☐ Yes ☐ No
ii.	Date of Injury:	(DD/MM/YYYY)
iii.	Report to Police	☐ Yes ☐ No
iv.	FIR NO	
v.	Injury /Disease caused due to substance abuse/alcohol consumption	☐ Yes ☐ No
vi.	Test conducted to establish this (if yes, attach report)	☐ Yes ☐ No

m. In case of Maternity ☐ G ☐ P ☐ L ☐ A

i. expected date of Delivery DD/MM/YYYY

DETAILS OF PATIENT ADMITTED

A. Date of admission — 6-6-23 (DD/MM/YYYY)

B. Time of admission — 4:00 (HH:MM)

C. Is this an emergency/planned hospitalization event: — Emergency ☐ Planned ☑

D. Mandatory Past History of any chronic illness — If yes (Since month/year)

i. Diabetes
ii. Heart disease
iii. Hypertension
iv. Hyperlipidemias
v. Osteoarthritis
vi. Asthma/COPD/Bronchitis
vii. Cancer
viii. Alcohol/Drug abuse
ix. Any HIV/ or STD Related ailment
x. Any other ailment, give details

— NIL —

E. Expected number of Days/stay in hospital — 01 Days

F. Days in ICU — _____ Days

G. Room Type — DAYCARE

H. Per day room rent+nursing and service charges+ patients diet

I. Expected cost of investigation + diagnostic

J. ICU charges

K. OT charges

L. Professional fees Surgeon + Anesthetist Fees + consultation Charges:

M. Medicines + Consumables + Cost of Implants (if applicable please specify)

N. Other hospital expenses if any — As per (SOC) PKG

O. All-inclusive package charges if any applicable

P. Sum Total expected cost of hospitalization — 26000/-

DECLARATION
(Please read very carefully)

We confirm having read understood and agreed to the Declarations of this form

a. Name of the treating doctor DR VARUN GOEL
b. Qualification: MBBS MD
c. Registration number with State code DMC-R04824

Hospital Seal
(Must include Hospital ID)

Patient/Insured Name and Sign

पृथ्वी, आग्न, जल, आकाश सबकी सुरक्षा हमारे पास

ओरिएण्टल इंश्योरेंस कम्पनी लिमिटेड

(भारत सरकार का उपक्रम)

CIN : U66010DL1947GOI007158

PRITHVI, AGNI, JAL, AKASH SABKI SURAKSHA HAMARE PA

THE ORIENTAL INSURANCE COMPANY LIMI

(A Govt. of India Undertaking)

Location: NOIDA

CIN : U66010DL1947GOI007158

HAPPY FAMILY FLOATER POLICY 2021 POLICY SCHEDULE

UIN: OICHLIP22010V042223

Policy No.	: 261298/48/2023/111	Prev. Policy No.	: 261204/48/2022/145
Cover Note No.	: -	Cover Note Date	: -
Insured's Code	: 154779207	Issue Office Code	: 261298
Insured Name	: SANWAR MAL (GSTIN: 0)	Issue Office Name	: BC BERI (GSTIN: 06AAACT0627R1Z3)
Address	: M/S PAHLAD RAI OMKAR MAL SHOP NO. 288 NEW GRAIN MARKET CH. DADRI - CHARKHI HARYANA 127306	Address	: The Oriental Insurance Co. Ltd Business Centre Beri Near PNB ATM BERI HARYANA 124201
Tel./Fax/Email	: / / 9812125773 / radheradhedinnu@gmail.com	Tel./Fax/Email	: 9416212739 / / bharat.jain@orientalinsurance.co.in

Agent/Broker Details

Dev.Off.Code : NA0000009432 DIRECT
Agent/Broker : BA0000100087 SH. ANIL KUMAR
Address : BACK SIDE ANAJ MANDI , CH. DADRI,BHIWANI,HARYANA,123306
Tel/Fax/Email : 9416329551//NA

Period of Insurance : FROM 00:00 ON 30/03/2023 TO MIDNIGHT OF 29/03/2024

Collection No. & Dt. : CHQ 9574000654 - 23/03/2023 GST INVOICE NO :0621289708 UIN :0

Gross Premium : 33,053 GST 5950 Stamp Duty : .5 Total : 39,003

Co-Insurance Details : Nil

Channel of Sale	Yes/No
1.Online	NO
2.Fresh	NO
3.Renewal	YES

TPA Details :

TPA ID : YA0000000343
TPA Name : M/S PARK MEDICLAIM INSURANCE TPA PRIVATE LIMITED
Address : 702, VIKRANT TOWERS RAJINDERA PLACE DELHI 110008 park@parkmediclaim.co.in
Telephone No : Toll Free No. : 1800115533, 011-25747454/55, FAX No. : 41539498

Number of persons covered : 2 Plan Type SILVER Plan Sum Insured : 500000

Particulars of the Persons covered :

Name of The	Gender	Age

Place : BERI
Date : 23/03/2023

IRDA-REGNO-558

For and on behalf of
The Oriental Insurance Company Limited

In case of any query regarding the Policy please call Toll Free No. 1800 11 8485 and 011 33208485.

Authorised Signatory

CIN: U66010DL1947GOI007158 All the Amounts mentioned in this policy are in Indian Rupees

Attached to and forming part of policy number 261298/48/2023/111

Sr. No.	Persons		Date of Birth		Relationship With Proposer	Pre-Existing Diseases	Co-Pay (%)	PA Capital Sum Insured (INR)
1	SANWAR MAL	M	31/12/1960	62	Self		10	
2	SHARDA DEVI	F	03/10/1966	56	Spouse Unemployed		10	

Nominee Details

Name Of the Nominee	Relationship With the Insured	Age Of the Nominee	M/F/TG*
SHARDA DEVI	REL_03	55	F

Optional Covers

	Yes / No	Remarks/Value
GEOGRAPHICAL EXTENSION TO SAARC COUNTRIES	NO	
RESTORATION OF SUM INSURED	NO	
PERSONAL ACCIDENT COVER: (WORLD¿ WIDE)	NO	
LIFE HARDSHIP SURVIVAL BENEFIT PLAN	NO	
WAIVER OF PROPORTIONATE DEDUCTION CLAUSE	NO	
WAIVER OF 10 % CO-PAY	NO	
		NO

Total Premium in words : Indian Rupees Thirty-Nine Thousand Three Only

The insurance under this policy is subject to conditions, clauses, warranties,endorsements as per forms attached.

The policy shall pay for hospitalisation expenses for medical/surgical treatment taken as an In-patient at any Nursing Home/Hospital in INDIA as defined in the policy.

In the event of a claim under the policy exceeding Rs. 1 lac or a claim for refund of premium exceeding Rs. 1 lac,the insured will comply with the provisions of the AML policy of the Company.The AML policy is available in all our operaing offices as well as Company's website

Warranted that in case the person covered under the policy has lodged any claim under the previous policy and the sum insured is enhanced under the current policy, for a further claim for the same disease during the current policy, the earlier limit of Sum Insured shall be applicable and not the enhanced sum insured.

Warranted that in case of dishonour of premium cheque(s) the Company shall not be liable under the policy and the policy shall be void abinitio (from inception).

"We at Oriental continuously strive to ensure that you get the best possible treatment from our network hospitals. Please contact your TPA or any of the Oriental offices for our preferred hospitals in your area before going for a treatment. This will help us serve you in the best possible manner"

Place : BERI
Date : 23/03/2023

IRDA-REGNO-558

For and on behalf of
The Oriental Insurance Company Limited

Authorised Signatory

In case of any query regarding the Policy please call Toll Free No. 1800 11 8485 and 011 33208485.

CIN: U66010DL1947GOI007158 All the Amounts mentioned in this policy are in Indian Rupees

1.Claim to be reported within 48 hrs of admission but before discharge.
2.Claim documents to be submitted within 15 days of discharge.
For complete details please refer to policy condition.

Policy History Data

Policy No.	Period From	Period To	Insurer Name	Sum Insured
261200/48/2016/3061	30-MAR-16	29-MAR-17	OICL ROHTAK	500000
261200/48/20217/3256	30-MAR-17	29-MAR-18	OICL ROHTAK	500000
261200/48/2018/2818	30-MAR-18	29-MAR-19	OICL ROHTAK	500000
261200/48/2019/1569	30-MAR-19	29-MAR-20	OICL ROHTAK	500000
261204/48/2020/162	30-MAR-20	29-MAR-21	OICL CH. DADRI	500000
261204/48/2021/149	30-MAR-21	29-MAR-22	OICL CH. DADRI	500000
261204/48/2022/145	30-MAR-22	29-MAR-23	The Oriental Insurance Company Ltd.	500000

Claim History Data

Policy no.	Claimant Name	Claim No.	Claim OS	Claim Paid
261204/48/2022/145	SANWAR MAL	261204/48/2023/00000009	.00	1,93,36.00
261204/48/2022/145	SANWAR MAL	261204/48/2023/00000018	10,20.00	
261204/48/2022/145	SANWAR MAL	261204/48/2023/00000013	.00	1,01,95.00
261204/48/2022/145	SANWAR MAL	261204/48/2023/00000008	.00	1,93,36.00

Place : BERI
Date : 23/03/2023

IRDA-REGNO-556

For and on behalf of
The Oriental Insurance Company Limited

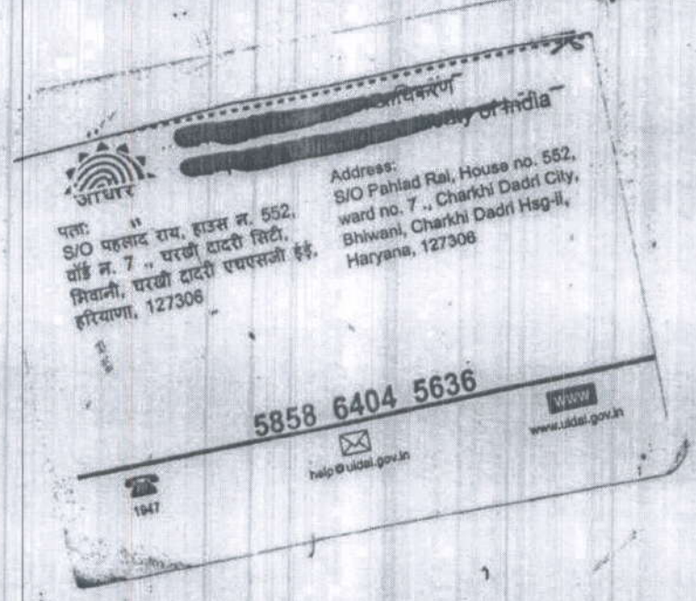
Rewari Area Bussiness Center

Authorised Signatory

In case of any query regarding the Policy please call Toll Free No. 1800 11 8485 and 011 33208485.

CIN: U66010DL1947GOI007158 All the Amounts mentioned in this policy are in Indian Rupees


सांवर मॉल
Sanwar Mal
जन्म तिथि / DOB : 31/12/1960
पुरुष / Male
5858 6404 5636
मेरा आधार, मेरी पहचान


आधार
पता:
S/O पहलाद राय, हाउस न. 552,
वॉर्ड न. 7 ,, चरखी दादरी सिटी,
भिवानी, चरखी दादरी एचएसजी ई,
हरियाणा, 127306
Address:
S/O Pahlad Rai, House no. 552,
ward no. 7 ,, Charkhi Dadri City,
Bhiwani, Charkhi Dadri Hsg-II,
Haryana, 127306
5858 6404 5636
help@uidai.gov.in
www.uidai.gov.in
1947

Mark of Excellence

E-mail : iclinix@gmail.com

iCLINIX
Advanced Eye Care
"Expert Care by AIIMS Alumni"
Centre for Retina & Lasers

QCI Accredited

Dr. Varun Gogia
MBBS (AIIMS), MD (AIIMS)
Senior Registrar (AIIMS)
Clinical Observer, Cleveland Clinic, USA
Honorary Visiting Consultant : Asan Eye Clinic, Dushanbe, Tajikistan
Senior Consultant Ophthalmology, Fortis C-DOC

Patient ID	10615	**Visit Date/Time**	06/Jun/2023 12:05 PM
Patient Name	Mr. Sanwar Mal	**Age/Sex**	60 Yrs / M
Patient Address	Gandhi Nagar Charkhi Dadri Haryana	**Contact No.**	9416852253
Category	General	**Old MR No.**	

Present Complaints

FOLLOW UP PT.

Vision	**Distance Vision**		**Near Vision**	
	Right Eye	Left Eye	Right Eye	Left Eye
Unaided	6/12	6/9	N24	N24
Best Correct	6/12	6/6	N18	N6

Method Name	**IOP Time**	**Right Eye**	**Left Eye**
NCT	12:08	16	17

Adv.Glasses	**Right Eye**						**Left Eye**					
	Sph	Cyl	Axis	Prism	V/A	N/V	Sph	Cyl	Axis	Prism	V/A	N/V
Distance	+0.00				6/12	N18	+0.00	+1.00	160		6/6	N6
Add	+2.50						+2.50					

Diagnosis Comments/Clinical Impression :

BE multiple lattices with holes

Doctor's Advice :

plan for BE LASER BARRAGE - 3 quadrents each eye

NEXT REVIEW : AS AND WHEN REQUIRED

Dr. Varun Gogia
MBBS(AIIMS), MD(AIIMS)
Director
DMC Reg.- R04624

Dr.Varun Gogia

MBBS(AIIMS), MD(AIIMS)

RATE LIST I CLINIX

S.NO	PROCEDURE	Rates(Rs)
1	Consultation charge(valid for 7 days)	700
2	OCT	3000
3	Ultrasound A Scan	1200
4	Fundus Photo	800
5	Fundus Fluorescein Angiography	4800
6	ICG Angiography	7500
7	ICG + Fluorescein Angiography	9000
8	OCT Angiography	7500
9	Green Laser Per Eye per Sitting (Single spot)	5000
10	Green Laser Per Eye per Sitting (Multi spot)	6000
11	Pan retinal Photocoagulation (4 sittings per eye)	20000
12	Laser Indirect Ophthalmoscope (LIO)- 1 quadrant per eye	6000
13	Laser Indirect Ophthalmoscope (LIO)- 2 quadrant per eye	10000
14	Laser Indirect Ophthalmoscope (LIO)- 3 quadrant per eye	13000
15	Laser Indirect Ophthalmoscope (LIO)- 4 quadrant per eye	16000
16	YAG Capsulotomy Per Eye	3500
17	YAG PI Per Eye	4500
18	Phaco+ Foldable IOL	32000
19	MICS + Foldable IOL	45000
20	MICS + Mulifocal IOL	80000
21	MICS + Toric	58000
22	MICS + Trifocal IOL	90000
23	Secondary IOL	30000
24	Scleral Fixation of IOL	45000
25	Retinal detachment Surgery (Scleral Buckling)	65000
26	Sutureless Vitrectomy Surgery (MIVS)	60000
27	MIVS (Vitrecromy) with Sil.Oil/Gas	65000
28	MIVS (Vitrecromy) with Sil.Oil/Gas with cataract	85000
29	MIVS (Vitrectomy) With Silicon oil/gas with Scleral Buckling	85000
30	MIVS (Vitrectomy) With Silicon oil/gas with Scleral Buckling with Cataract	1,05000
31	Anterior Vitrectomy	32000
32	Silicon Oil Removal	32000
33	Squint Surgery (2 Muscles)	45000
34	Squint Surgery (3 Muscles)	50000
35	Squint Surgery (4 Muscles)	55000
36	Glaucoma Surgery (Trab+MMC)	45000
37	Ahmed Glaucoma Valve Surg.For Glaucoma	65000
38	Lucentis Injection	24000

ICLINIX - Advanced Eye Care
Lajpat Nagar-IV
N.D.-24

PPN NETWORK - DECLARATION BY PATIENT/PATIENT'S ATTENDANT

Name of the Hospital **I Clinix Advanced Eye Care** Date :... 6/6/23

Address : **27/171 Vikram Vihar, Lajpat Nagar-4, Near Moolchand Metro Station, New Delhi-110024**

PATIENT NAME (BLOCK LETTERS) :.....SAWAR MAL..... **AGE/SEX :**.....62/M.....

IP No :..... **UHID No :**..... **Mobile No of Patient :**.....9416852253.....

Date of Admission :.....6-6-23..... **Time of Admission :**.....4:40.....

Date of Discharge :.....6-6-23..... **Time of Discharge :**.....

Address of the Patien:.....

NAME OF THE ATTENDANT :.....**Relationship with the Patient :**.....

Mobile No. of Attendant :..... **Address:**.....

Declaration regarding Insurance Policy (Strike off the option which is not applicable)

(i) ***Declaration when patient has no insurance policy:***

- I declare that I do not have any insurance policy.

(ii) ***Declaration when patient has insurance policy:***

- I declare that I have following Insurance Policies

Policy No/TPA card No: 261298/48/2023/111

Insurance Company: ORIENTAL INS. CO

2) Whether patient opted for Eligible Room Category under Policy:
Yes / No

3) In case, policyholder wishes to avail better facility:

Name of the Additional Facility/ Provision/ Procedure/ Treatment:
----------which costs Rs
:..... (In words:
.....) only.

On my own option, I wish to avail above better facility and I hereby agree to pay on my free will, after being explained in detail by the Hospital authority in my own and understandable language about the above mentioned Additional Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed PPN tariff. Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as per agreed PPN tariff rates and balance amount will be borne by myself or patient only.

I have also been explained that when room service of a category better than eligible room rent is availed by the patient, not only the difference in room rent but also an equal proportion of all other charges associated with the treatment shall be borne by me.

Signature : Diwan Rs
Name of the ~~Patient~~/Patient's attendant:

Signature : **Ms. Zenab**
Name of the Hospital Representative & Hospital Seal :